Statement of

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on

Medicare Governance: Perspectives on the Health Care Financing Administration

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Chairman Baucus, Senator Grassley, and members of the committee, my name is Michael E. Gluck, and I am happy to be here today as you consider the management and governance of the Medicare program.

Since last fall I have been on the faculty at Georgetown University's Institute for Health Care Research and Policy. For the five previous years, I was Director of Health Policy Studies at the nonpartisan National Academy of Social Insurance (NASI) where I headed up staff work for a large project examining Medicare's long-term future, including an on-going study of the program's administration. Since coming to Georgetown, my colleague Richard Sorian and I have continued work in this area with funding from the Public Policy Institute of AARP. We will be writing over the next several months about the challenges and potential remedies for Medicare administration. As part of both projects, I have engaged in structured conversations with over 50 individuals who have hands-on experience with the Health Care Financing Administration, now to be known as the Centers for Medicare and Medicaid Services (CMS). They include providers, beneficiary representatives, political appointees at the agency from both parties, current and former career employees, and others. I am happy to be here today to share with you some of what I have learned from my work at both NASI and Georgetown. In my testimony, I speak only for myself and not for NASI, AARP, or any other organization.

I would like to begin this morning by suggesting two general themes that I believe characterize CMS at this time, and I will then move on to what I see as the most important challenges the agency faces and some ideas for addressing them.

As someone who has been a student of Medicare policy with particular interest in the program's benefits and financing, the sheer enormity of the program's administration is most impressive. CMS must carry out an extraordinarily large number of diverse an complicated operational tasks. In general these include:

- management of contracts to pay claims for traditional (fee-for-service) Medicare
- management of Medicare+Choice contracts
- assuring adequate beneficiary information and services
- safeguarding program integrity
- making national coverage decisions
- implementing payment rates and procedures
- overseeing the survey and certification of health care facilities and other quality assurance activities
- setting standards and writing regulations to carry out many of these functions
- overseeing demonstrations and research to improve the program, plan for future financing, and to understand Medicare's role in the overall health care system

In addition to Medicare, CMS also has responsibilities for Medicaid, the State Children's Health Insurance program (SCHIP), and parts of the Health Insurance Portability and Accountability Act (HIPAA). Even though CMS contracts with other organizations to carry out many of these activities, it must still coordinate, oversee, and

assure consistency among these contractors. Often CMS can only indirectly manage contractors' work even though it is ultimately accountable to Congress, beneficiaries, providers, and other taxpayers for how well these contractors do their jobs. Over time, CMS's responsibilities have grown with the adoption of prospective payment, the growing complexity of medical practice, and the growth of Medicare managed care. Even though Medicare's administrative budget has not grown to match these new challenges, beneficiaries get the health care they need and providers generally are paid accurately and on time. I will return to the issue of CMS's budget later in this testimony.

Another important theme to emerge from our work is that CMS has multiple goals and that these can conflict with one another. In general these goals are:

- protecting beneficiaries (i.e. assuring access to and quality of health care)
- protecting providers and suppliers (i.e. assuring timely payment for services provided)
- protecting the taxpayer (i.e. assuring the Medicare trust funds are appropriately spent)

The potential conflicts among these goals have increased as Medicare and health care have become more complex. For example, regulations to protect patient rights in Medicare+Choice plans impose some costs and burdens on health plans and providers. So too do data requirements for risk adjustment designed to assure that plans are paid properly and that beneficiaries have access to them. Similarly, efforts to eliminate waste, fraud, and abuse (i.e. protecting the taxpayer) can impose burdens on other providers. Tradeoffs among these goals are an inherent feature of the Medicare program and CMS's mission and will create inevitable tensions for CMS as it works its various constituencies.

I would now like to turn to the most important challenges facing CMS – staffing, information technology, Medicare's administrative budget, provider and beneficiary services, and contractor reform.

Staffing

According to the experienced CMS-watchers whom we interviewed, staffing and information technology are the agency's most pressing needs. These are also perhaps the most amenable to intervention.

In the case of staffing, the experts with whom we spoke saw the problem to be more about the backgrounds and experience of current CMS employees than their actual numbers. CMS had 4219 full time equivalent employees in FY 1999, up somewhat from 3,979 two years earlier.[1] However, the agency has little capacity to attract individuals with experience in private health insurance. One example of how this lack of private experience may place CMS at a disadvantage is the concept of value purchasing of health care. In the old world of health insurance upon which Medicare and CMS were modeled,

[1] Health Care Financing Administration, Justification of Estimates for Appropriations Committees. Fiscal Year 2001.

a health plan simply paid claims. The idea that a health care payer should rigorously seek value for money had not yet entered the work of health care. Today this idea is a fundamental goal of today's private health insurance. However, few at CMS have had the opportunity to learn how private health plans try to incorporate value purchasing into their business.

There is a perception among many outside of CMS that the agency has a conscious or unconscious bias against managed care in favor of the traditional fee-for-service program. Our analysis suggests that the problem is actually a general lack of in-house experience with how modern private health insurance plans go their business, whether they are fee-for-service or an HMO.

Some have suggested creating a new agency to manage Medicare+Choice and any potential new drug benefit, leaving CMS to manage the traditional fee-for-service program. Our analysis suggests that a better and sufficient alternative would be to hire new CMS staff with relevant private sector experience. Not only could this strategy invigorate both traditional Medicare program and Medicare+Choice, it would also avoid the potential lack of coordination and confusion for beneficiaries that could result from having two agencies running the Medicare program.

Our work also indicates significant difficulties in CMS's ability to attract sufficient numbers of physicians and experts in cutting edge information technology.

The limiting factor appears to be CMS's salary structure. The agency simply cannot provide compensation sufficient to compete with private health plans for the best and brightest. A number of our interviewees also pointed to the agency's inability to retain talented young professionals at the agency given the better salaries they can garner in the private sector. Even if the number of Medicare beneficiaries receiving their health care through managed care plans, the agency will still require talented staff with a good understanding of private health plans to oversee Medicare+Choice and traditional Medicare.

Among the options Congress may want to consider are adjustments and supplements to CMS's compensation structure sufficient to attract individuals from the private sector, medicine, and the information technology industry. The Public Health Service has the authority to pay Senior Scientist supplements to assure it can retain the talent it needs. Other parts of the federal government also have the flexibility to pay more to maintain a skilled workforce.

Providing CMS staff with the opportunity to be "detailed" to appropriate private organizations for a time would be an additional way for the agency to take on more of the philosophy and relevant best practices of the private sector. According to a 1991 report of the National Academy of Public Administration, 71 percent of HCFA staff at that time

were 40 years or older, and 25 percent were 50 years or older.[2] Long-time agency employees have begun to retire and more will do so during the next decade. This presents a golden opportunity to bring new talent and a new outlook to the agency through the natural attrition of current staff.

Information Technology

Computers have been vital to CMS's work since the beginning of the Medicare program. They are the main mechanism for paying providers on time and according to Medicare's rules for reimbursable services. They are also tools in assuring program integrity and quality health care. Through the Medicare Compare database, we have seen the very beginnings of how information technology might help Medicare better serve its beneficiaries and their families. However, our interviews, along with the excellent work of the General Accounting Office and other,s underscore how far CMS's information technology is from achieving its full potential.

Medicare's computer technology is antiquated. Most of the systems were developed in the early 1970s. At that time, data were processed in batches with delays and constraints on one's ability to integrate information from different sources and points in time. This contrasts with current technology in many organizations that allows information to be available to a user as soon as it is entered. Furthermore, CMS and its contractors must update computer code in a patchwork fashion in order to incorporate new payment rules. Two years ago, CMS achieved Y2K compliance in the same fashion. Such patches take time and create a risk for error as the number of patches compound. Delays in the availability of useful data mean they are often not available for policy planning, quality improvement, or program accountability. The lack of timely data also limits the program's ability to solve the problems for individual beneficiaries and providers.

There are also multiple computer systems to support Medicare operations. The number of systems itself is not the problem. In fact, the experience of the Medicare Transaction System (MTS) in the 1990s suggests that it may be inadvisable to expect one system to do everything. However, it is a significant problem that the various systems cannot easily "talk" to one another. Each fiscal intermediary, carrier, and other Medicare contractor has its own data system. Although all systems are expected to conform to standards, it is difficult (and not routine) to pull data from different contractors to put together a profile of services and payments involving a particular beneficiary or provider, or to look in aggregate across different Medicare services.

How should CMS go about improving its computer systems? To its credit, the agency does have a strategic plan for its information technology. In our interviews, we discussed the MTS experience and the factors that led to its abandonment. Despite the

[2] National Academy of Public Administration. An Agency At Risk: An Evaluation of Human Resources Management at HCFA. A Report for the Health Care Financing Administration in fulfillment of contract no. 500-90-0018. Washington, DC. September 1991.

problems with MTS, we found universal agreement that Medicare must invest significantly in its computer systems. Our interviews suggested a few other ideas as well:

- Although Medicare's computer systems should be integrated across different services and contractors, changes should be made in discrete pieces and staggered over time. This will allow CMS to alter later phases of the project to incorporate lessons learned in implementing the earlier phases. It also provides CMS with additional opportunities to measure how well its contractors are fulfilling their obligations and, if necessary, change contractors.

- The scope of work for developing and implementing the new information technology system should be as specific as possible. Several interviewees indicated that a lack of specificity of the contract's scope of work contributed to the failure of MTS. This suggestion underscores the need for CMS to hire additional staff with a thorough understanding of both cutting-edge computer technology and the best management practices of private health plans.

- One interesting idea that emerged from our work is that CMS might commission several prototype systems before settling on a single contractor much as the Department of Defense does when procuring a new jet fighter. Although CMS would spend some money on systems it would not ultimately develop, the agency would reduce the risk of contracting with a single firm that might fail. Furthermore, the final information technology system could incorporate the best elements of each of the prototypes.

The Administrative Budget

CMS has been proud of its lean budget, recently boasting, that Medicare's administrative expenses "are less than two percent [of benefit payments,] far below the private insurance industry average of 12 percent."[3] HCFA's administrative budget includes funds for its contractors, its own staff and infrastructure, the Peer Review Organizations (PROs), and State Health Insurance Assistance Programs (SHIPs). In reality, these amounts have been too low given the growing size of the program and the dramatic increase in the number and complexity of administrative tasks we expect it to perform. Any significant restructuring of the program or the addition of a prescription drug benefit (whether integrated into Medicare or offered through private health plans) will add to Medicare's administrative responsibilities.

In the interest of spending each tax dollar wisely, there may be a tendency to assume that administrative expenditures are wasteful – i.e. that they support a government bureaucracy rather than directly providing benefits. CMS's unique appropriations process may contribute to this tendency with the result of under-investing in program administration. Most of CMS's administrative funds are discretionary, while

[3] Health Care Financing Administration, "Medicare 2000: 35 Years of Improving Americans' Health and Security" July 2000.

federal Medicare and Medicaid health benefits are mandatory spending. For other federal health agencies, such as the National Institutes of Health, administrative budgets are considered together with expenditures designed to improve health. Despite the significant role CMS plays in improving the health and well-being of 70 million Americans, only its administrative budget is the focus of the appropriations process. CMS's administrative budget must compete for funds against human genome research and many other popular programs in the Department of Health and Human Services.

Rather than assuming administrative expenditures could be better spent in some other way, it may be useful to consider them as investments -- investments to assure the Medicare tax dollar is spent well, investments to assure that beneficiaries receive quality health care, and investments to assure that providers and suppliers are paid.[4] Under this rubric, the question becomes what return are we realizing for our administrative expenditures. In some cases, we may realize a greater return by investing more money.

One option suggested by others[5] for which there is precedent would be to set the administrative budget for Medicare (and the other mandatory programs for which CMS has responsibility) according to a formula related to benefit payments. This is already done for the Social Security Administration's administrative budget, for Medicare PRO program, and for the SHIP program. In order to maintain accountability and assure an appropriate administrative budget, Congress could review the formula along with CMS's administrative priorities and accomplishments every few years with the advice of Medpac, GAO, or some other expert body. Adjustments should reflect Congress' expectations of the agency. For example, major changes like the adoption of a prescription drug benefit or significant new payment rules for providers should be accompanied by appropriate increases in administrative budgets.

Beneficiary and Provider Services

Services Through Contractors. The reorganization announced by Secretary Thompson this past week stresses the need for CMS to "respond to all constituencies faster and better." Our work suggests that the strain on Medicare's administrative budget has hit provider and beneficiary services particularly hard. Medicare contractors have traditionally been the first and best source of information for physicians and other providers trying to understand Medicare's payment rules and to resolve billing problems. They have also served as a resource for beneficiaries trying to resolve problems or confusion over their Medicare claims. As budgets have become tighter in recent years, contractors have received less for provider and beneficiary services. Funds for provider education have held steady at $15.8 million over the last three years, down from $31.4

[4] Blumenthal, D, "Administrative Issues in Health Care Reform," New England Journal of Medicine. 329 (August 5, 1993) 6: 428-429. U.S Congress, Office of Technology Assessment, International Comparisons of Administrative Costs in Health Care, BP-H-135. Washington, DC: U.S. Government Printing Office, September 1994.

[5] See for example, Vladeck B.C. and Cooper B.S. "Making Medicare Work Better," New York: Institute for Medicare Practice, Mount Sinai School of Medicine. March 2001.

million in FY 1995.[6] Funds for beneficiary communications have held steady at $181.6 million for the last two years. Because contractors' first priority is to pay claims in a timely fashion, their ability to provide beneficiary and provider service has suffered.

For providers, an important element of the services they need from contractors is education and guidance about billing and reimbursable services. The vast majority of providers want to bill Medicare correctly for the services they provide to beneficiaries, but they need help in understanding the complexities of Medicare's rules. At a time when Congress has made the elimination of improper payments a priority for Medicare, such education is a vital.

Carriers and fiscal intermediaries should also be in the best position to help beneficiaries understand how the Summary of Benefits forms they receive relate to the care they have sought and any bills providers have sent to them. We found strong support among our interviewees for providing contractors with the necessary funds to provide these important services.

Other Sources of Information for Beneficiaries. Our analysis and the opinions of the experts with whom we spoke indicate that CMS has come a long way since 1997 in developing written materials explaining Medicare and the choices available to beneficiaries. Much thought, research, and testing has gone into the *Medicare Handbook* that each beneficiary receives in the fall as well as the Medicare Compare website, the toll-free telephone line, and the information available to private organizations that help beneficiaries understand their benefits and choose a health plan.

While these resources are now excellent, comprehensible references for beneficiaries and their families, the next step is for CMS to develop better resources to help beneficiaries with their own particular needs. Other research that my colleagues and I undertook at NASI indicated that most beneficiaries seek information only when they need it and look for information tailored to their individual health and financial circumstances.[7] In choosing a health plan,[8] beneficiaries seek a plan with particular benefits they think they will need. When beneficiaries encounter problems with claims or coverage, they seek out individuals who can resolve the situation and offer clear individualized explanations.

Current sources of individualized help are limited. The toll-free telephone line is limited to helping beneficiaries make health plan choices. In an effort to assure that

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[6] Tilson S., Congressional Research Service. Memorandum to the Senate Finance Committee on "HCFA Budget, Organization, and Staffing Information." Washington, DC. January 30, 2001.

[7] Bernstein J, Gluck M.E., "Medicare Managed Care and Choice: What Do Californians Have to Say," in Iglehart, J.K., ed., *Medicare and Managed Care: A Primer from Health Affairs and the California HealthCare Foundation*. Millwood, VA: Project Hope, 1999.

[8] In this case, health plan refers to either the traditional fee-for-service Medicare program or a Medicare+Choice option.

beneficiaries receive correct information, the telephone agents work from scripts. They do not attempt to give individualized advice. They refer beneficiaries with claims problems to the appropriate Medicare contractor. They can also refer beneficiaries to the SHIP in their area. Our interviews suggest that the SHIPs are under-funded and vary from state to state in how well they meet beneficiaries' needs. They all rely on volunteers. In some SHIPs, close contact with the contractors and CMS regional offices facilitate solving beneficiaries' problems. In other states, the relationships with contractors and regional offices are less well-developed.

The limited resources for individualized beneficiary help has led some to suggest that CMS itself should have a local presence, such as one employee in each Social Security district office. Others in our interviews have suggested that the internet and modern telecommunications would allow CMS to provide the same individualized service in a more cost-effective manner. Our initial analysis suggests that the right course of action is not obvious, and we will be conducting a more detailed examination of these options in the coming months. However individualized beneficiary services are provided, the counselors need competent and ongoing training as well as good access to data and individuals from the local carriers, intermediairies, and regional offices.

Contractor Reform

In the area of more contractor reform, the types of restrictions placed on Medicare contracting in the 1965 statute appear out-of-sync with the complexity of the current health care marketplace and Medicare. We found strong support in our interviews for continuing to reduce the number of contractors as well as for furthering the flexibility first given to CMS as part of HIPAA in the types of services for which the agency may contract. Other suggestions that we have not yet analyzed in any detail include more competitive selection of contractors and tying some part of contractor compensation to objective measures of their performance.

Other Issues

In my testimony, I have focused on issues where we have found some agreement across the experts with whom we spoke. There are other questions where there was less consensus and for which we will do additional analysis to characterize the problems and potential solutions. For example:

- Over the last two years, CMS has implemented an impressive transformation in its process for national coverage decisions to make them more transparent and evidence-based. However, several important questions still remain: What should be the role of national coverage decisions versus contractor and regional decisions in evaluating new medical technologies, particularly as biomedical innovation changes medical practice at such a fast pace? What criteria should be used in making coverage decisions? Can and should such decisions be insulated from the political process?

- CMS has ten regional offices around the country. Our interviews suggest a potential lack of coordination between the regional and central offices in some aspects of Medicare operations. What roles should these regional offices play, and how can we assure sufficient coordination and communications?

- A number of interviewees as well as other recent policy reports[9] have suggested making CMS an independent agency outside of the Department of Health and Human Services as was done for the Social Security Administration. What are the pros and cons of this proposal?

As my colleagues and I grapple with these questions in the current months, we would be happy to share our analyses and conclusions with you.

I thank you for this opportunity to participate today, and I am happy to answer any questions you may have.

[9] Vladeck and Cooper, *op.cit.*